Turn-Around Communication/Referral Form Between EES and Head Start/Early Head Start

10-03

EES

Client Name: _____ KsCares ID#: _____

Child Name: _____

Address: _____

Street City State Zip

Telephone Number: _____

Comments: _____

_____

_____

_____

EES Worker: _____ Date: _____

Head Start/Early Head Start

Client Name: _____ is participating in Head Start/Early Head Start activities.

Comments/Questions: _____

_____

_____

_____

Head Start/Early Head Start Staff: _____ Date: _____

Permission to Release Information: My signature on this form authorizes the Kansas Department for Children and Families (DCF) and Head Start/Early Head Start to share information about my situation. This release is valid from the date set out below and shall remain valid until revoked in writing by the undersigned.

_____

Client Signature Date